## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/17/2012 FORM APPROVED OMB NO. 0938-0391

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	ULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  WILLOW CROSSING HEALTH & REHABILITATION CENTER  (X4) ID (CA) ID (EACH DEFICIENCE STATE)  (CA) ID (EACH DEFICIENCY WIST SET REFECCEDED BY TOUL REGULATORY OR LSC IDENTIFYING INFORMATION)  (F 000)  INITIAL COMMENTS  This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint #IN00113659.  This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00110725 and IN00111334 Survey completed on 7/18/12.  Complaint #IN00113659 - corrected.  Survey dates: September 10 and 11, 2012  Facility number: 105535  AlM number: 100267710  Survey team: Jill Ross, RN  Census bed type: SNF: 7  SNF/NF: 54 Total: 61  Census payor type: Medicare: 7 Medicaid: 48 Other: 6 Total: 61  Sample: 3  Willow Crossing Health and Rehab was found to be in compliance with 42 CFR Part 483, Subpart			155535	B. WIN	IG			
IEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   TAG	NAME OF PROVIDER OR SUPPLIER				35	550 CENTRAL AVE	,	
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Census payor type: Medicare: 7 Medicaid: 48 Other: 6 Total: 61 Sample: 3 Willow Crossing Health and Rehab was found to be in compliance with 42 CFR Part 483, Subpart	{F 000}	This visit was for a P the Investigation of C This visit was in conju Revisit (PSR) to the i IN00110725 and IN00 on 7/18/12.  Complaint # IN00113  Survey dates: Septer Facility number: 0005 Provider number: 155 AIM number: 100267  Survey team: Jill Ros Census bed type: SNF: 7	ost Survey Revisit (PSR) to omplaint # IN00113659. unction with a Post Survey envestigation of Complaint 0111334 Survey completed 659 - corrected. enber 10 and 11, 2012 672 6535 710	{F (	000}			
Revisit (PSR) to the Investigation of Complaint # IN00113659.		Census payor type: Medicare: 7 Medicaid: 48 Other: 6 Total: 61 Sample: 3 Willow Crossing Heal be in compliance with B and 410 IAC 16.2 in Revisit (PSR) to the I IN00113659.	n 42 CFR Part 483, Subpart n regard to the Post Survey nvestigation of Complaint #					(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155535	B. WING			R-C <b>09/11/2012</b>	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	_	3550	r address, city, state, zip code Central ave .UMBUS, in 47203		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIENC REGULATORY OR		ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTIO TAG CROSS-REFERENCED TO THE DEFICIENCY)		SHOULD BE COMPLETION		
{F 000}	Continued From pag Quality review compl Cathy Emswiller RN		{F (	000}			